INTRODUCING YOUR EMPLOYEE BENEFITS PROGRAM

The State of Idaho is pleased to provide a comprehensive benefit program to eligible employees. The program offers you and your family a variety of group insurance benefits including:

- **Blue Cross of Idaho Traditional, PPO and High Deductible Medical Plans:** These plans provide hospital, physician, prescription drug and vision benefits. EAP benefits are included in each medical plan, with claims management provided by ComPsych.
- thriveidaho**:** Health promotion plan available to all employees enrolled in in one of the state's medical plans. Visit the thriveidaho website to find out how to get started earning rewards.
- **Blue Cross Dental Plan**: Covered under this plan are routine and preventive care, basic services, major services and orthodontia.
- **Life Insurance:** The Basic Life plan is provided to all eligible employees by the State, at no cost to them. Also available is an optional Voluntary Term Life plan for all eligible employees and State Police Optional Life, for all eligible police officer members of the Idaho State Police.
- **Disability Program**: Short Term Disability and Long Term Disability coverages automatically provided to all eligible employees as part of the Basic Life plan, at no cost to them.
- **Flexible Spending Accounts:** The Medical Reimbursement and Dependent Care Reimbursement Accounts allow eligible employees an opportunity to set aside tax exempt funds to pay out-of-pocket health and dependent care expenses.
- **Premium Only Plan:** Lets you save money by having your monthly medical and dental premiums deducted from your pay on a pre-tax basis.

This is a summary of the State of Idaho employee benefit programs. Since this is just a brief overview of how the plans work and the benefits they pay, it does ***not*** include all the details about plan provisions, exclusions or limitations. To get the details, be sure to refer to the individual plan contracts.

All plans are administered by the Director of the Department of Administration. The Director is empowered to amend or terminate these plans or any benefits provided by these plans at any time. Participants will be notified as to any such changes as required by governing regulations. Neither this summary nor any of the State's policies for benefit plans should be considered a contract for purposes of employment or payment of compensation or benefits.

The Director exercises the ultimate discretionary authority and control over the plan and the management and disposition of plan assets. Benefit payments are subject to the provisions of each plan contract. The costs associated with this publication are available from the Department of Administration, Office of Group Insurance in accordance with Section 60-202, Idaho Code – 01/97/2, 500/530l-0461.

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IMPORTANT NUMBERS AND ADDRESSES

OFFICE OF GROUP INSURANCE

The Office of Group Insurance, Department of Administration as established in Idaho Code 67, Chapter 57, sponsors and administers all group medical, dental, life, accidental death and dismemberment, disability, and Flexible Spending Account insurance contracts and policies for the employees of the State of Idaho and their dependents.

To ask questions or obtain information about your benefit coverage, contact the Office of Group Insurance at:

Street Address: 304 N 8th Room 432, Boise, ID
Mailing Address: P.O. Box 83720
Boise, ID 83720-0035
Phone Number: 208-332-1860 (Local)
1-800-531-0597 (Toll-Free Long Distance)
TDD Voice Relay: 1-800-377-1363
TDD Service with Text: 1-800-377-3529
Email: **ogi@adm.idaho.gov**

BENEFITS ONLINE

Learn about available benefits by going online to the Office of Group Insurance website at or the State of Idaho Employee Portal.

BENEFIT PLANS

Plan	Address	Phone
Blue Cross of Idaho Medical and Dental Plans	***Blue Cross of Idaho*** P.O. Box 7408 Boise ID 83707 www.bcidaho.com	208-331-8897 or 1-866-804-2253 (toll-free long distance)
Life Insurance Plans	***Principal Life Insurance Co.***	208-332-1860 or 1-800-531-0597
Disability Program	***Principal Life Insurance Co.***	208-332-1860 or 1-800-531-0597
Flexible Spending Accounts	***Stanley, Hunt, DuPree, Rhine and Associates, Inc.*** P.O. Box 6400 Greenville, SC 29606 www.shdr.com	1-800-930-2441 or 1-800-768-4873

ABOUT THE PLANS

Here is a brief summary of general provisions of the State of Idaho's employee group insurance plans. Remember, for more details refer to the individual plan contracts.

ELIGIBLE EMPLOYEES

You are eligible for benefits if you are an officer or employee of a State department, agency or institution, working twenty (20) hours or more per week and your term of employment is expected to exceed five (5) continuous months. Employees receive coverage only when they meet the eligibility requirements. There are certain limitations as to employment classifications, which can be found in the individual plan documents or contracts in this summary.

ELIGIBLE DEPENDENTS

Eligible Dependents include the following: (1) your legal spouse and/or (2) your or your legal spouse's children up to their 26th birthdays, unless the dependent children are eligible to enroll in their own employer based group coverage. The term "children" includes natural children, stepchildren, adopted children, or children in the process of adoption from time placed with you. The term "children" also includes children legally dependent upon you or your spouse for support where a normal parent-child relationship exists with the expectation that you will continue to rear that child to adulthood. However, if one or both of that child's natural parents live in the same household with you, a parent-child relationship shall not be deemed to exist even though you or your spouse provides support.

DUAL COVERAGE

No one may be simultaneously insured under any of the State plans:

- As a member of more than one insurance class;
- As an insured individual and an insured dependent; or
- As more than one insured individual or insured dependent.

INITIAL ENROLLMENT AND WHEN COVERAGE BEGINS

When you start work as an eligible employee, you will need to complete all the applicable enrollment documents before benefits begin. Your human resources or payroll office will provide all the materials you will need.

Here is a quick look at enrollment rules for the various plans and when coverage may begin under each:

Plans	When You May Enroll	When Coverage May Begin
Medical	Anytime after you are hired as an eligible employee.	If you enroll: • Within 30 days of your hire date, the first day of the month following date of hire. • After 30 days, the first day of the month following date of application.
Dental	Automatic when you enroll for medical.	When your medical coverage begins.
Basic Life Insurance	No enrollment required for employees or eligible dependents.	The first day of the month following date of hire.
Voluntary Term Life Insurance	Anytime after you are hired as an eligible employee.	If you enroll: • Within 30 days of your hire date, the first day of the month following date of hire. • Within 31 days of a qualifying life event (marriage, divorce, birth, adoption or job change), the first day of the month following the life event. • After 30 days without a qualifying life event, evidence of insurability will be required before you can enroll.
State Police Optional Life Insurance	Anytime after you are hired as an eligible employee.	If you enroll: • Within 30 days of your hire date, the first day of the month following date of hire. • After 30 days, proof of good health will be required. Coverage begins the first of the month after your application is approved.
Disability Coverage	No enrollment required.	The day your Basic Life coverage becomes effective.
Flexible Spending Accounts	Within 30 days of your hire date or during annual Open Enrollment.	If you enroll: • Within 30 days of your hire date, the first day of the month following date of hire. If you do not enroll during the initial 30 day eligibility period you must wait until the following Open Enrollment period.
Premium Only Plan	Within 30 days of your hire date. Enrollment required to elect or decline participation.	• If you enroll, your share of monthly costs will be deducted on a pre-tax basis starting the first paycheck your monthly premiums are withheld. • If you decline participation, you will pay your share of monthly premiums on a post-tax basis for the rest of the contract year.

WAITING PERIODS

Medical Plans

The State employee medical plans have a twelve (12)-month waiting period for pre-existing conditions for anyone who is age 19 or older. Please refer to the Blue Cross contracts for specific details.

If you were covered by another medical plan within sixty-three (63) days of your date of hire with the State and you enroll for coverage within thirty (30) days of employment, the time enrolled under the prior plan may count toward fulfilling this twelve (12) month waiting period. For more information, contact the Office of Group Insurance.

Dental Plan

For all new dental plan enrollees, there is a twelve (12) month waiting period for major care (covered crowns, bridges, dentures) and orthodontia services. Please refer to the Blue Cross Dental Plan contract for specific details.

Your time enrolled in a prior dental plan cannot be credited against the waiting period in the State's dental plan.

COORDINATION OF BENEFITS (COB)

In addition to your State plan coverage, if you or your enrolled dependents are covered under another group medical or dental plan, the plans' COB provisions will apply. Under COB, State plans will coordinate with your other plans to pay up to, but no more than, the total amount of covered expenses. Refer to the specific plan contract for COB details.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Individual insurance carriers administer all health insurance policies in compliance with applicable Idaho and Federal law. If a court enters a QMCSO or other order regarding enrollment of or payment of medical expenses for a dependent child or alternate recipient, you must provide a copy of the order to the Office of Group Insurance. Your insurance carrier will comply with the order to the extent possible.

WHEN COVERAGE ENDS

Your coverage under the various State sponsored benefit plans ends on the earliest of these dates:

- You cease to be a State employee. If your active status ends:
    - *Before the 15th of a month*, coverage will continue through the end of that month; or
    - *On or after the 15th of a month*, coverage will continue through the end of the following month;
- You cease to be eligible; or
- The plan is terminated.

For your enrolled dependents, coverage ends when your coverage ends or the end of the month in which they cease to be eligible for the plans — whichever comes first.

BENEFITS WHILE ON A LEAVE OF ABSENCE

The State allows employees to take paid and unpaid leaves of absence for a variety of reasons. For more about when and under what circumstances a leave may be approved, contact your Human Resources Office.

Leave Without Pay (LWOP)

You may continue Medical, Dental, Basic Life, Voluntary Term Life and/or State Police Optional Life coverages for up to six (6) months (twelve [12] months if you are on employer-sponsored leave for professional or educational purposes), by self-paying the full monthly premiums, including any amount the State usually pays for active employees.

Disability insurance is *not* available for continuation during your leave — State-paid coverage ends after thirty (30) days, counted from the first day after your leave starts.

Leave With Pay

While you are on authorized leave with pay, you will maintain your active status. Consequently, your Medical, Dental, Basic Life, Voluntary Term Life and/or State Police Optional Life coverages will continue the same as for any other active employee. That means your payroll deductions will continue as usual.

Family Medical Leave Act (FMLA)

- **Medical and Dental:** The State will continue to pay its share of the premiums, the same as for active employees, while you continue to pay your share during approved FMLA leave. If you exhaust your twelve (12) week FMLA leave, you can continue coverage by self-paying the full cost for the balance of six (6) months following your initial date of leave.

- **Basic Life:** During the FMLA period, the State will pay the monthly premiums. After that, you can continue coverage by self-paying the full cost for a maximum of six (6) months from your initial date of leave.

- **Voluntary Term Life and Police Optional Life:** For up to six (6) months from the date you go on leave, by self-paying the full premiums.

Disability Leave

When you file a disability claim, the Office of Group Insurance will send you a detailed explanation of your options for continuing coverage, including your required premium contributions. In general, you may continue State coverage as follows:

- **Medical and Dental:** For up to thirty (30) months from your date of disability (as determined by our disability insurance carrier, Principal Life Insurance Company), or until your disability claim closes, whichever occurs first. During this period, you must pay your share of the monthly premium. While you are in active status (exhausting leave time), your share of the premium will continue to be deducted from your paycheck and your agency will continue to pay the employer's share. Once you are on inactive status, you may self-pay your portion of the monthly premium and the Office of Group Insurance will pay the employer's share of the premium for the balance of the coverage continuation period.

- **Basic Life and Voluntary Term Life:** For as long as your disability claim is open. Basic Life will continue at no cost to you. If you become disabled before age 60 your Voluntary Term Life coverage will be continued for as long as your disability claim is open, provided you pay the premiums during the first six (6) months following your date of disability. While you are in active status, premiums will continue to be deducted from your paycheck. Once you are inactive, you will need to self-pay your portion of the monthly premium.

- **State Police Optional Life:** For as long as your disability claim is open. You must pay the premiums for the first six (6) months of your approved disability. While you are in active status, premiums will continue to be deducted from your paycheck. Once you are inactive, you will need to self-pay your portion of the monthly premium.

COBRA RIGHTS

After your eligibility for group coverage ends, you may be able to purchase continued medical and dental coverages, on an individual basis, for a period of time under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If you are an FSA enrollee, you may be eligible to continue your Medical Reimbursement Account participation on a post-tax contribution basis.

COBRA Qualifying Events

The duration of COBRA coverage available to you depends on the specific qualifying event:

Qualifying Event	Individuals Eligible for COBRA	Duration of COBRA Coverage
Your termination of employment Your reduced working hours	Employee Spouse Dependent child	Up to 18 months from the date Active plan coverage ends
Your death Your divorce or legal separation	Spouse Dependent child	Up to 36 months from the date Active plan coverage ends
Loss of dependent child status	Child	Up to 36 months from the date Active plan coverage ends

COBRA Extensions

The eighteen (18) month COBRA period may be extended up to twenty-nine (29) months in the event you are disabled according to the Social Security Administration. Additional information about the twenty-nine (29) month COBRA period is available from the Office of Group Insurance.

If another qualifying event takes place during the eighteen (18) month continuation period that would entitle your dependents to a longer period of continued coverage, the COBRA period for your dependents may be extended. At the most, however, coverage cannot be extended more than thirty-six (36) months.

COBRA Election

To continue coverage, the insured person must complete a COBRA continuation enrollment form within sixty (60) days after group coverage terminates. The COBRA participant must pay the required monthly costs for the continuation of coverage. If you have any questions or need COBRA enrollment forms, contact the Office of Group Insurance at ogi@adm.idaho.gov.

Termination of COBRA

COBRA coverage will end on the earliest of the following dates:

- At the end of the applicable eighteen (18), twenty-nine (29) or thirty-six (36) months of coverage continuation;
- The date the required contributions are no longer made;
- The date the COBRA participant becomes entitled to Medicare;

- The date the COBRA participant becomes covered by any other group health plan — if the new plan does not exclude or limit the person's coverage for preexisting conditions as a result of employment, reemployment or marriage; or

- The date the State terminates health care coverage for all employees.

CONVERSION PRIVILEGES

When COBRA medical coverage ends, you may be able to convert to an individual policy offered by your medical carrier. Also, after your group life insurance coverage ends, you may be able to convert to an individual policy offered by your life insurance carrier — no evidence of insurability is required if you apply within thirty-one (31) days after your group coverage ends. Conversion policies are not available for disability coverage or dental coverage.

Costs, provisions and benefits of conversion policies may differ substantially from those of the group plans. To find out more about medical conversion policies, contact your insurance carrier. Contact the Office of Group Insurance for life insurance conversion information.

RETIREE BENEFITS

The state offers Retirees and their eligible dependents the choice of Blue Cross of Idaho PPO, Traditional and High Deductible medical plans. To be eligible a retiree must have been hired on or before June 30, 2009, be under age 65, have at least 20,800 hours of credited state service, be receiving monthly retirement benefits from a State Retirement System and retire directly from state service. Retirees hired after June 30, 2009 are not eligible for coverage unless they have credited state service of at least 20,800 hours before June 30, 2009 and subsequent to reemployment, election or reappointment on or after July 1, 2009 accumulate an additional 6,240 continuous hours of credited state service and are otherwise eligible for coverage.

You can find more information regarding the state's retiree medical plans, including dependent eligibility requirements, online at ogi.idaho.gov/retirees/

FISCAL YEAR 2014 PREMIUMS

MEDICAL AND DENTAL COVERAGES

You and the State share in the cost of these coverages. How much you pay depends on which plan you choose, how many family members are enrolled and how many hours per week you work. Premiums are deducted on the first and second paydates of each month to pay for the following month's coverage.

BIMONTHLY MEDICAL AND DENTAL PREMIUM RATES

Full-Time Tier (30 to 40 hours per week)
Employer Medical Contribution: $372.12
Employer Dental Contribution: $ 7.04

	Employee Only	Employee & Spouse	Employee & Child	Employee & Children	Employee, Spouse & Child	Employee, Spouse & Children
PPO Plan	$17.50	$44.50	$30.50	$41.00	$55.50	$63.50
Traditional Plan	$21.50	$54.00	$38.00	$49.50	$67.50	$75.50
High Deductible Plan	$14.00	$37.50	$25.50	$34.50	$47.00	$53.00
Dental	$ 4.00	$18.50	$15.50	$23.75	$26.37	$30.50

Part-Time Tier (20 – 29.9 hours per week)
Employer Medical Contribution: $297.70
Employer Dental Contribution: $ 5.63

	Employee Only	Employee & Spouse	Employee & Child	Employee & Children	Employee, Spouse & Child	Employee, Spouse & Children
PPO Plan	$ 88.75	$115.75	$101.75	$112.25	$126.75	$134.75
Traditional Plan	$ 92.75	$125.25	$109.25	$120.75	$138.75	$146.75
High Deductible Plan	$ 74.50	$ 98.00	$ 86.00	$ 95.00	$107.50	$113.50
Dental	$ 6.25	$ 20.75	$ 17.75	$ 26.00	$ 28.62	$ 32.75

PREMIUM ONLY PLAN (POP)

The Premium Only Plan allows you to elect to have the premiums you pay for group medical and dental insurance coverages deducted from your paychecks on a pre-tax basis before Federal or state income taxes or FICA taxes (Social Security/Medicare) taxes are withheld. For details about the plan, please refer to the Flexible Spending Account plan document. After initial enrollment, you may change your POP election *only* during the annual open enrollment period.

BASIC LIFE

The State pays the premium for this coverage — there is no cost to you.

DISABILITY COVERAGE

The State pays the full monthly cost for Short Term Disability and Long Term Disability coverages. **NOTE: Since this coverage is employer-paid, if you ever become disabled under the plan you may have to pay income and FICA (Medicare/Social Security) taxes on some or all of the benefits you receive.**

VOLUNTARY TERM LIFE INSURANCE

If you elect this coverage, you pay the entire monthly premium. How much you will pay depends on your benefit amount and your age group. Following are rates for Fiscal Year 2014.

Your Age	Employee Coverage Monthly Rates Per $1,000 Coverage	Spouse Coverage Monthly Rates Per $10,000 of Coverage
35 and under	.08	$0.80
36-40	.12	$1.20
41-45	.17	$1.70
46-50	.27	$2.70
51-55	.43	$4.30
56-60	.77	$7.70
61-65	1.04	$10.40
66-70	1.59	$15.90
71-75	2.27	$22.70
76-80	3.43	$34.30
81-85	5.11	$51.10

Child Coverage	Monthly Premium Per Family
$10,000	$2.00

STATE POLICE OPTIONAL LIFE

If you elect this coverage, you will pay half of the $6.78 monthly premium and the State will pay the other half.

MEDICAL PLANS

Eligible employees can enroll themselves and their eligible dependents for medical coverage, and have the choice of a Blue Cross of Idaho Traditional, PPO or High Deductible plan. For details about the plans, please refer to the plan contracts. **To locate participating providers, refer to the Blue Cross of Idaho Provider directory.**

HOW THRIVEIDAHO WORKS

thriveidaho is an employee health promotion program designed to reward and promote healthy lifestyles through a variety of programs and resources for state of Idaho employees. The program is available to all employees enrolled in one of the state's Blue Cross of Idaho medical plans. Learn how to start earning your rewards at thrive.idaho.gov!

HOW THE BLUE CROSS OF IDAHO TRADITIONAL PLAN WORKS

After you pay an annual deductible, the plan generally pays eighty percent (80%) of most Allowable Charges. You can use any provider you want — but you may save money when you use providers who belong to the Blue Cross of Idaho network of participating providers.

- **Participating Providers** have negotiated with Blue Cross of Idaho to provide plan participants with services at the plan's Allowable Charges. That means they will accept plan benefits plus your share of the costs (any deductible, coinsurance or copayments) as payment in full.

- **Non-participating Providers** may charge more than the plan's Allowable Charges, which means you are responsible for any amounts that exceed the Allowable Charges plus any deductible and coinsurance amounts.

HOW THE BLUE CROSS OF IDAHO PPO PLAN WORKS

The PPO provides for In-Network and Out-of-Network benefits for most commonly provided services. After you pay an annual deductible, the plan generally pays eighty-five percent (85%) of most Allowable Charges provided by an In-Network provider. In-Network Physician Office Visits (office exam only) require a $20 copayment and are not subject to the annual deductible. Eligible Out-of-Network services are subject to a separate deductible, and are generally reimbursed at seventy percent (70%) of most Allowable Charges.

The PPO is not a managed care plan and you are not required to select a primary care physician. In addition, **referrals are not required under the plan;** you can use any provider you want. However, you save money when you use providers who belong to the Blue Cross of Idaho PPO network of participating providers.

- **In-Network Providers** have negotiated with Blue Cross of Idaho to provide plan participants with services at the plan's Allowable Charges. That means they will accept plan benefits plus your share of the costs (any deductible, coinsurance or copayments) as payment in full.

- **Out-of-Network Providers** may charge more than the plan's Allowable Charges, which means you are responsible for any amounts that exceed the Allowable Charges plus any deductible and coinsurance amounts.

HOW THE BLUE CROSS OF IDAHO HIGH DEDUCTIBLE PLAN WORKS

After you pay an annual deductible, the plan generally pays seventy percent (70%) of most Allowable Charges. You can use any provider you want — but you may save money when you use providers who belong to the Blue Cross of Idaho network of participating providers.

- **Participating Providers** have negotiated with Blue Cross of Idaho to provide plan participants with services at the plan's Allowable Charges. That means they will accept plan benefits plus your share of the costs (any deductible, coinsurance or copayments) as payment in full.

- **Non-participating Providers** may charge more than the plan's Allowable Charges, which means you are responsible for any amounts that exceed the Allowable Charges plus any deductible and coinsurance amounts.

MEDICAL PLAN BENEFITS AT A GLANCE

BLUE CROSS TRADITIONAL PLAN

The following benefits outline is an easy reference document that contains general payment information. To be eligible for benefits, Covered Services must be Medically Necessary and must be provided to an eligible insured under the terms of this policy. For plan details, including other covered expenses, exclusions and limitations, please refer to the contract. **NOTE:** Annual amounts, including deductibles, out-of-pocket amounts and benefit limits, are based on a policy year. A policy year runs from July 1 through June 30.

Plan Features	Blue Cross of Idaho Traditional Plan
Deductibles • Individual	Insured pays first $350 of eligible expenses per Benefit Period
• Family	Insureds pay a combination of $1,050 of eligible expenses for all Insureds under same Family Coverage per Benefit Period. *(No Insured may contribute more than the Individual Deductible amount toward the Family Deductible.)*
Out-of-pocket Limit ***Deductible plus Coinsurance*** • Individual	Insured pays $4,300 of eligible expenses per Benefit Period When an Insured has met the Out-of-pocket Limit, the benefits payable on behalf of the Insured for Covered Services will increase to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for vision care, dental covered services, and Prescription Drug Covered Services.
• Family	Insureds pay a combination of $8,600 of eligible expenses per Benefit Period
Out-of pocket expenses associated with the following are not included in the Out-of-pocket Limit: • Amounts that exceed the Maximum Allowance. • Amounts that exceed benefit limits. • Dental Covered Services, except Dental Services Related to Accidental Injury. • Vision Care Covered Services. • Prescription Drug Covered Services. • Noncovered services or supplies.	When Insureds have met the Out-of-pocket Limit, the benefits payable on behalf of all the Insureds for Covered Services will increase to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for vision care, dental covered services, and Prescription Drug Covered Services. (No Insured may contribute more than the Individual Out-of-pocket Limit toward the Family Out-of-pocket Limit.)
Annual Maximum Benefit Limit	BCI pays up to $2,000,000 on behalf of an Insured each Benefit Period. All Covered Services apply towards the Annual Maximum Benefit Limit except for Chiropractic Care Services, Diabetes Self-Management Education Services, Hospice Services, Transplant Travel Benefits and Temporomandibular Joint (TMJ) Syndrome Services.

Services BCI Covers	Traditional Plan Amount of Payment
Physician Office Visits	BCI pays 80% of Maximum Allowance after Deductible
Hospital Services • Includes coverage for newborn nursery charges.	BCI pays 80% of Maximum Allowance after Deductible
Employee Assistance Program (EAP) • Administered and preauthorized by ComPsych 1-877-427-2327.	1 – 5 visits per person per Benefit Period
Wellness/Preventive Care Services For specifically listed Covered Services For services not specifically listed *Specific benefits are for:* • *Well Baby care and Well Child care – routine or scheduled examinations, including Rubella and PKU tests* • *Adult examinations – annual physical examinations, including pap tests, preventive screening mammogram services, fecal occult blood test, PSA tests, cholesterol panel, and CBC and SMAC blood tests and Diabetes Screening.* • *For enrolled eligible females as required by Women's Preventive Health Care: transmittable Diseases Screening (Chlamydia, Gonorrhea, Human Immunodeficiency Virus (HIV), Human papillomavirus (HPV), Syphilis, Tuberculosis (TB). For Enrollee or the Enrolled Eligible Dependent spouse: Diabetes Screening for Pregnant Women.* • *Immunizations – Accellular Pertussis, Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pneumococcal (pneumonia), Poliomyelitis (polio), Rubella, Tetanus, Varicella (Chicken Pox) and routine immunizations included in the State of Idaho Vaccine for Children Program, as amended or revised.* *Other immunizations may be covered at the discretion of BCI when Medically Necessary.* *No benefits are provided for travel vaccines.*	BCI pays 100% of the Maximum Allowance BCI pays 80% of the Maximum Allowance after Deductible BCI pays 80% of the Maximum Allowance after Deductible

Traditional Plan Prescription Drug Benefits		
	Contracting	**Noncontracting**
Tier 1: Generic Drugs **Tier 2: Formulary Brand Name Drugs** **Tier 3: Non-Formulary Brand Name Drugs** **<u>Maintenance Drugs Only</u>** One (1) Copayment for ***each*** 30-day supply Two (2) Copayments for ***each*** 60-day supply Three (3) Copayments for ***each*** 90-day supply of Maintenance drugs only (1-30 day supply, 1 Copayment; 31-60 day supply, 2 Copayments, 61-90 day supply, 3 Copayments) **<u>Nonmaintenance Drugs</u>** Limited to a 30-day supply at one time **Note:** Certain prescription drugs have Generic equivalents. If the Insured or Provider requests a Brand Name Drug and a Generic Drug is available, the Insured is responsible for the difference between the price of the Generic Drug and the Brand Name Drug plus any applicable Copayment.	Insured pays $10 per prescription Insured pays $25 per prescription Insured pays $50 per prescription	Insured pays $10 per prescription* Insured pays $25 per prescription* Insured pays $50 per prescription* * For a covered Prescription Drug dispensed by a Physician or a Licensed Pharmacist who is not a Participating Pharmacist, the Insured is responsible for paying for the Prescription Drug at the time of purchase and must submit a claim to BCI or one (1) of its designated claims processing vendors. The amount of payment for a covered Prescription Drug is the balance remaining after subtracting the Prescription Drug Copayment and/or Coinsurance from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.
Diabetes Management **Insulin Syringes/Needles** Insulin syringes/needles covered if purchased within 30 days of Insulin purchase (only 1 copayment required) **Other Diabetic Supplies** Benefits shall be provided for blood sugar diagnostics: • lancets • test strips (blood glucose and urine) • alcohol swabs	Insulin subject to above listed pharmacy copayments. Insured pays $10 per item	Insulin subject to above listed pharmacy copayments. Insured pays $10 per item
Prescribed Contraceptives	BCI pays 100% for Women's Preventive Prescription Drugs and devices as specifically listed on the BCI Web site, www.bcidaho.com; Deductible does not apply. The day supply allowed shall not exceed a 90-day supply at one (1) time, as applicable to the specific contraceptive drug or supply.	
Human Growth Hormone Therapy (Prior Authorization required**)**	Subject to above listed pharmacy copayments	Subject to above listed pharmacy copayments

Traditional Plan Vision Care Benefits	
Plan Features	VSP Pays Up to the Amounts Listed
Professional Fees	• Eye Exam $50
Materials – Lenses Per Pair Single Vision, up to Bifocal, up to Trifocal, up to Lenticular, up to Frame, up to	 $50 $80 $95 $125 $50
Contact Lenses – Per Pair Elective, up to Medically Necessary, up to	 $70 $125
Service Frequency Limitations	Insured may receive one (1) eye exam every twelve (12) months. Insured may receive one (1) pair spectacle lenses or contact lenses every twelve (12) months. Insured may receive one (1) frame every twenty-four (24) months.
Value Added Discounts from a VSP Participating Doctor	The following discounts apply when visiting a VSP Participating Doctor: • 20% savings on lens options like progressives and scratch resistant coatings when a complete pair of glasses is received. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor. • 20% off additional pairs of glasses and non-prescriptioin sunglasses, including non-covered lens options. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor. • 15% off cost of contact lens exam (evaluation and fitting); materials not included. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor.

BLUE CROSS PPO PLAN

The following benefits outline is an easy reference document that contains general payment information. To be eligible for benefits, Covered Services must be Medically Necessary and must be provided to an eligible insured under the terms of this policy. For plan details, including other covered expenses, exclusions and limitations, please refer to the contract. **NOTE:** Annual amounts, including deductibles, out-of-pocket amounts and benefit limits, are based on a *policy year*. A policy year runs from July 1 through June 30.

Plan Features	PPO Plan In-Network	PPO Plan Out-Of-Network
Deductibles: • Individual	Insured pays first $250 of eligible expenses per Benefit Period, except for Covered Services that require a Copayment	Insured pays first $500 of eligible expenses per Benefit Period
• Family	Insureds pay a combination of $750 of eligible expenses for all Insureds under same Family Coverage per Benefit Period, except for Covered Services that require a Copayment *(No insured may contribute more than the Individual Deductible amount toward the Family Deductible).*	Insureds pay a combination of $1,500 of eligible expenses for all Insureds under same Family Coverage per Benefit Period *(No Insured may contribute more than the Individual Deductible amount toward the Family Deductible.)*
Out-of-pocket Limit ***Coinsurance plus Deductible*** • Individual	Insured pays $3,250 of eligible expenses per Benefit Period.	Insured pays $6,500 of eligible expenses per Benefit Period.
• Family	Insureds pay a combination of $6,750 of eligible expenses per Benefit Period.	Insureds pay a combination of $13,500 of eligible expenses per Benefit Period.
Out-of-pocket expenses associated with the following are not included in the Out-of-pocket Limit: • Amounts that exceed the Maximum Allowance. • Copayments. • Amounts that exceed benefit limits. • Dental Covered Services, except Dental Services Related to Accidental Injury. • Vision Care Covered Services. • Prescription Drug Covered Services. • Noncovered services or supplies.	*When the Out-of-pocket Limit is met, benefits payable for Covered Services increases to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for dental covered services, vision care, Prescription Drug Covered Services, and amounts exceeding benefit limits.* *(No Insured may contribute more than the Individual Out-of-Pocket Limit toward the Family Out-of-Pocket Limit.)*	*When the Out-of-Pocket Limit is met, benefits payable for Covered Services increases to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for dental covered services, vision care, Prescription Drug Covered Services, and amounts exceeding benefit limits.* *(No Insured may contribute more than the Individual Out-of-Pocket Limit toward the Family Out-of-Pocket Limit.)*
• **Annual Maximum Benefit Limit**	BCI pays up to $2,000,000 on behalf of an Insured each Benefit Period. All Covered Services apply towards the Annual Maximum Benefit Limit except for Chiropractic Care Services, Diabetes Self-Management Education Services, and Hospice Services.	

Services BCI Covers	Amount of Payment	
	PPO Plan In-Network	PPO Plan Out-of-Network
Physician Office Visits	Insured pays $20 Copayment per visit *(*Any additional services, such as lab, x-ray, and other Diagnostic Services are subject to Deductible and Coinsurance*).*	BCI pays 70% of Maximum Allowance after Deductible.
Hospital Services • Includes coverage for newborn nursery charges	BCI pays 85% of Maximum Allowance after Deductible.	BCI pays 70% of Maximum Allowance after Deductible.
Employee Assistance Program (EAP) • Administered and preauthorized by ComPsych 1-877-427-2327	1 – 5 visits per person per Benefit Period.	
Wellness/Preventive Care Services For specifically listed services • *Well-Baby and Well-Child Care – routine or scheduled well-baby and well-child examinations, including Rubella and PKU tests* • *Adult examinations – annual physical examinations, including pap tests, preventive screening mammogram services, fecal occult blood tests, PSA tests, cholesterol panel, and CBC and SMAC blood tests, and Diabetes Screening.* • *For enrolled eligible females as required by Women's Preventive Health Care: transmittable Diseases Screening (Chlamydia, Gonorrhea, Human Immunodeficiency Virus (HIV). Human papillomavirus (HPV), Syphilis, Tuberculosis (TB). For Enrollee or the Enrolled Eligible Dependent spouse: Diabetes Screening for Pregnant Women.*	BCI pays 100% of Maximum Allowance (Deductible does not apply)	BCI pays 70% of Maximum Allowance after Deductible.
For services not specifically listed	BCI pays 85% of Maximum Allowance after Deductible.	
Immunizations • *Accellular Pertussis, Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pneumococcal (pneumonia), Poliomyelitis (polio), Rubella, Tetanus, Varicella (Chicken Pox) and routine immunizations included in the State of Idaho Vaccine for Children Program as amended or revised*	Listed immunizations require No Copayment, Deductible, or Coinsurance	BCI pays 70% of Maximum Allowance after Deductible.
Other immunizations not specifically listed may be covered at the discretion of BCI when Medically Necessary.	Subject to Deductible and Coinsurance.	
No benefits are provided for travel vaccines		

PPO Plan Prescription Drug Benefits		
	In-Network	**Out-of-Network**
Tier 1: Generic Drugs **Tier 2: Formulary Brand Name Drugs** **Tier 3: Non-Formulary Brand Name Drugs** **<u>Maintenance Drugs Only</u>** One (1) Copayment for ***each*** 30-day supply Two (2) Copayments for ***each*** 60-day supply Three (3) Copayments for **each** 90-day supply of Maintenance drugs only (1-30 day supply, 1 Copayment; 31-60 day supply, 2 Copayments, 61-90 day supply, 3 Copayments) **<u>Nonmaintenance Drugs</u>** Limited to a 30-day supply at one time **Note:** Certain prescription drugs have Generic equivalents. If the Insured or Provider requests a Brand Name Drug and a Generic Drug is available, the Insured is responsible for the difference between the price of the Generic Drug and the Brand Name Drug plus any applicable Copayment.	Insured pays $10 per prescription. Insured pays $25 per prescription. Insured pays $50 per prescription.	Insured pays $10 per prescription* Insured pays $25 per prescription* Insured pays $50 per prescription* * For a covered Prescription Drug dispensed by a Physician or a Licensed Pharmacist who is not a Participating Pharmacist, the Insured is responsible for paying for the Prescription Drug at the time of purchase and must submit a claim to BCI or one (1) of its designated claims processing vendors. The amount of payment for a covered Prescription Drug is the balance remaining after subtracting the Prescription Drug Copayment and/or Coinsurance from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.
Diabetes Management **Insulin Syringes/Needles** Insulin syringes/needles covered if purchased within 30 days of Insulin purchase. (only 1 copayment required) **Other Diabetic Supplies** Benefits shall be provided for blood sugar diagnostics: • lancets • test strips (blood glucose and urine) • alcohol swabs	Insulin subject to above listed pharmacy copayments. Insured pays $10 per item.	Insulin subject to above listed pharmacy copayments. Insured pays $10 per item.
Prescribed Contraceptives	BCI pays 100% for Women's Preventive Prescription Drugs and devices as specifically listed on the BCI web site, www.bcidaho.com; Deductible does not apply. The day supply allowed shall not exceed a 90-day supply at one (1) time, as applicable to the specific contraceptive drug or supply.	
Human Growth Hormone Therapy (Prior Authorization required**).**	Subject to above listed pharmacy copayments	Subject to above listed pharmacy copayments

PPO Plan Vision Care Benefits	
Plan Features	VSP Pays Up to the Amounts Listed
Professional Fees Eye Exam	 $50
Materials – Lenses Per Pair Single Vision, up to Bifocal, up to Trifocal, up to Lenticular, up to Frame, up to	 $50 $80 $95 $125 $50
Contact Lenses – Per Pair Elective, up to Medically Necessary, up to	 $70 $125
Service Frequency Limitations	Insured may receive one (1) eye exam every twelve (12) months. Insured may receive one (1) pair spectacle lenses or contact lenses every twelve (12) months. Insured may receive one (1) frame every twenty-four (24) months.
Value Added Discounts from a VSP Participating Doctor	The following discounts apply when visiting a VSP Participating Doctor: • 20% savings on lens options like progressives and scratch resistant coatings when a complete pair of glasses is received. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor. • 20% off additional pairs of glasses and non-prescriptioin sunglasses, including non-covered lens options. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor. • 15% off cost of contact lens exam (evaluation and fitting); materials not included. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor.

BLUE CROSS HIGH DEDUCTIBLE PLAN

The following benefits outline is an easy reference document that contains general payment information. To be eligible for benefits, Covered Services must be Medically Necessary and must be provided to an eligible insured under the terms of this policy. For plan details, including other covered expenses, exclusions and limitations, please refer to the contract. **NOTE:** Annual amounts, including deductibles, out-of-pocket amounts and benefit limits, are based on a *policy year*. A policy year runs from July 1 through June 30.

Plan Features	High Deductible Plan
Deductibles • Individual	Insured pays first $2,000 of eligible expenses per Benefit Period
• Family	Insureds pay a combination of $6,000 of eligible expenses for all Insureds under same Family Coverage per Benefit Period. *(No Insured may contribute more than the Individual Deductible amount toward the Family Deductible.)*
Out-of-pocket Limit ***Deductible plus Coinsurance*** • Individual	Insured pays $5,000 of eligible expenses per Benefit Period When an Insured has met the Out-of-pocket Limit, the benefits payable on behalf of the Insured for Covered Services will increase to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for vision care, dental covered services, and Prescription Drug Covered Services.
• Family Out-of Pocket expenses associated with the following are not included in the Out-of-pocket Limit: • Amounts that exceed the Maximum Allowance. • Amounts that exceed benefit limits. • Dental Covered Services, except Dental Services Related to Accidental Injury. • Vision Care Covered Services. • Prescription Drug Covered Services. • Noncovered services or supplies.	Insureds pay a combination of $10,000 of eligible expenses per Benefit Period When Insureds have met the Out-of-pocket Limit, the benefits payable on behalf of all the Insureds for Covered Services will increase to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for vision care, dental covered services, and Prescription Drug Covered Services. **(No Insured may contribute more than the Individual Out-of-pocket Limit toward the Family Out-of-pocket Limit.)**
Annual Maximum Benefit Limit	BCI pays up to $2,000,000 on behalf of an Insured each Benefit Period. All Covered Services apply towards the Annual Maximum Benefit Limit except for Chiropractic Care Services, Diabetes Self-Management Education Services, Hospice Services, Temporomandibular Joint (TMJ) Syndrome Services, and Transplant Travel Benefits.

Services BCI Covers	High Deductible Plan Amount of Payment
Physician Office Visits	BCI pays 70% of Maximum Allowance after Deductible.
Hospital Services • Includes coverage for newborn nursery charges	BCI pays 70% of Maximum Allowance after Deductible
Employee Assistance Program (EAP) • Administered and preauthorized by ComPsych 1-877-427-2327.	1 – 5 visits per person per Benefit Period
Wellness/Preventive Care Services • For specifically listed Covered Services • For services not specifically listed *Specific benefits are for:* • *Well Baby care and Well Child care – routine or scheduled examinations, including Rubella and PKU tests* • *Adult examinations – annual physical examinations, including pap tests, preventive screening mammogram services, fecal occult blood test, PSA tests, cholesterol panel, and CBC and SMAC blood tests, and Diabetes Screening.* • *For enrolled eligible females as required by Women's Preventive Health Care: transmittable Diseases Screening (Chlamydia, Gonorrhea, Human Immunodeficiency Virus (HIV), Human papillomavirus (HPV), Syphilis, Tuberculosis (TB). For Enrollee or the Enrolled Eligible Dependent spouse: Diabetes Screening for Pregnant Women.* • *Immunizations – Accellular Pertussis, Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pneumococcal (pneumonia), Poliomyelitis (polio), Rubella, Tetanus, Varicella (Chicken Pox) and routine immunizations included in the State of Idaho Vaccine for Children Program, as amended or revised* Other immunizations not specifically listed may be covered at the discretion of BCI when Medically Necessary No Benefits are provided for travel vaccines	BCI pays 100% of Maximum Allowance BCI pays 70% of Maximum Allowance after Deductible BCI Pays 70% of the Maximum Allowance after Deductible

High Deductible Plan Prescription Drug Benefits		
	Contracting	**Noncontracting**
Tier 1: Generic Drugs **Tier 2: Formulary Brand Name** **Tier 3: Non-Formulary Brand Name Drugs** **<u>Maintenance Drugs Only</u>** One (1) Copayment for ***each*** 30-day supply Two (2) Copayments for ***each*** 60-day supply Three (3) Copayments for **each** 90-day supply of Maintenance drugs only (1-30 day supply, 1 Copayment; 31-60 day supply, 2 Copayments, 61-90 day supply, 3 Copayments) **<u>Nonmaintenance Drugs</u>** Limited to a 30-day supply at one time **Note:** Certain prescription drugs have Generic equivalents. If the Insured or Provider requests a Brand Name Drug and a Generic Drug is available, the Insured is responsible for the difference between the price of the Generic Drug and the Brand Name Drug plus any applicable Copayment.	Insured pays $10 per prescription Insured pays $25 per prescription Insured pays $50 per prescription	Insured pays $10 per prescription* Insured pays $25 per prescription* Insured pays $50 per prescription* * For a covered Prescription Drug dispensed by a Physician or a Licensed Pharmacist who is not a Participating Pharmacist, the Insured is responsible for paying for the Prescription Drug at the time of purchase and must submit a claim to BCI or one (1) of its designated claims processing vendors. The amount of payment for a covered Prescription Drug is the balance remaining after subtracting the Prescription Drug Copayment and/or Coinsurance from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.
Diabetes Management **Insulin Syringes/Needles** Insulin syringes/needles covered if purchased within 30 days of Insulin purchase (only 1 copayment required) **Other Diabetic Supplies** Benefits shall be provided for blood sugar diagnostics: • lancets • test strips (blood glucose and urine) • alcohol swabs	Insulin subject to above listed pharmacy copayments. Insured pays $10 per item	Insulin subject to above listed pharmacy copayments. Insured pays $10 per item
Prescribed Contraceptives	BCI pays 100% for Women's Preventive Prescription Drugs and devices as specifically listed on the BCI Web site, www.bcidaho.com; Deductible does not apply. The day supply allowed shall not exceed a 90-day supply at one (1) time, as applicable to the specific contraceptive drug or supply.	
Human Growth Hormone Therapy (Prior Authorization required**)**	Subject to above listed pharmacy copayments	Subject to above listed pharmacy copayments

High Deductible Plan Vision Care Benefits	
Plan Features	VSP Pays Up to the Amounts Listed
Professional Fees Eye Exam, up to	 $50
Materials – lenses per pair Single Vision, up to Bifocal, up to Trifocal, up to Lenticular, up to Fram, up to	 $50 $80 $95 $125 $50
Contact Lenses – per pair Elective, up to Medically Necessary, up to	 $70 $125
Service Frequency Limitations	Insured may receive one (1) eye exam every twelve (12) months. Insured may receive one (1) pair spectacle lenses or contact lenses every twelve (12) months. Insured may receive one (1) frame every twenty-four (24) months.
Value Added Discounts from a VSP Participating Doctor	The following discounts apply when visiting a VSP Participating Doctor: • 20% savings on lens options like progressives and scratch resistant coatings when a complete pair of glasses is received. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor. • 20% off additional pairs of glasses and non-prescriptioin sunglasses, including non-covered lens options. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor. • 15% off cost of contact lens exam (evaluation and fitting); materials not included. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor.

MORE ABOUT YOUR MEDICAL BENEFITS

Electing or Declining Coverage

Enrollment information is available from your human resources or payroll representative. To enroll yourself and eligible dependents, **you must complete an online enrollment form** if your agency is on the State Controller's Payroll system, or a hardcopy form if your agency maintains its own payroll system. To *decline* medical coverage, complete the *declination of coverage* section of the enrollment form.

Once you have enrolled in a medical plan, you may not change to another plan until the next Open Enrollment period.

Changing Elections

After your initial enrollment period, you may:

- *Add family members* at any time. You have sixty (60) days to enroll new family members acquired through marriage, birth or adoption. Coverage for a new spouse or stepchildren will begin the first of the month following your date of marriage. Newborns and newborn adoptive children have coverage on their date of birth; adoptive children older than sixty (60) days will have coverage effective on their date of placement with you. **If you wait longer than sixty (60) days to submit an enrollment form, coverage will be effective the first day of the month following the date you apply for coverage**.

- *Drop coverage for yourself or dependents at any time.*

Filing Medical Claims

After you enroll, you will receive an identification card from Blue Cross of Idaho. Whenever you receive services from a participating or In-Network provider, just show your ID card — the provider will bill the carrier on your behalf.

When you use a non-participating or Out-of-Network provider, you may have to make a claim for reimbursement.

- Submit a detailed invoice from your provider. Be sure to include your name and Blue Cross of Idaho subscriber identification number. The address is:

  Blue Cross of Idaho
  Attn: Claims
  P.O. Box 7408
  Boise, ID 83707

Filing Vision Benefit Claims

Blue Cross of Idaho contracts with Vision Service Plan (VSP) for administration of vision benefits. When you use a VSP contracting provider, you won't need to submit the claim - your provider will bill VSP for you. If you use a non-participating VSP provider, you may need to submit the claim yourself.

- Submit a detailed invoice from your provider. Be sure to include your name, subscriber Blue Cross identification number, and the name of your employer (State of Idaho). The address is:

  VSP
  PO Box 997105
  Sacramento CA 95899-7105

DENTAL PLAN

The State offers Blue Cross of Idaho Dental coverage to you and your eligible family members. Participation in the plan is automatic for employees enrolled in one of the State's medical plans but must be elected for eligible dependents. **NOTE:** Dental coverage is available ***only*** to those enrolled in a State employee medical plan.

DECLINING DEPENDENT DENTAL

Employees can decline dental coverage for their dependents at any time. To do that, select "Self only" in the Dental Enrollment section of the medical/dental enrollment form. **Once you have declined dependent dental coverage, you may only elect it again at the next annual open enrollment period**.

HOW THE BLUE CROSS DENTAL PLAN WORKS

With this plan you can use any provider you want — but you may save money when you use providers who belong to the Blue Cross of Idaho network of participating providers.

- **In-Network Providers** have negotiated with Blue Cross of Idaho to provide plan participants with services at the plan's Allowable Charges. That means they will accept plan benefits plus your share of the costs (any deductible, coinsurance or copayments) as payment in full.

- **Out-of-Network Providers** may charge more than the plan's Allowable Charges, which means you are responsible for any amounts that exceed the Allowable Charges plus any deductible and coinsurance amounts.

To locate participating providers, please refer to the Blue Cross of Idaho provider directory.

DENTAL PLAN BENEFITS AT A GLANCE

Here is a brief look at how the Blue Cross Dental Plan pays covered expenses. If you use the services of a Blue Cross Dental contracting provider, benefits will be paid at Traditional or PPO participating provider levels based on the contracting status of your dentist at the time services are rendered.

For details about the plan, including limitations, exclusions and waiting periods, please refer to the contract.

DENTAL CARE BENEFITS	
For Covered Providers and Services	
Benefit Limit	$1,000 per Insured, per Benefit Period
Orthodontic Lifetime Limit	$1,000 per Insured
Deductible: Individual	Insured pays $25 per Benefit Period (Deductible does not apply to Preventive/Diagnostic Dental Covered Services received from a PPO Contracting Provider)

DENTAL CARE BENEFITS	In-Network		Out-of-Network
	PPO Contracting Providers	**Traditional Contracting Providers**	*(When you choose an Out-of-Network Provider you are responsible for the difference between what BCI allows and what the Out-of-Network Provider charges)*
Preventive/Diagnostic Dental Services	BCI pays 80% of Maximum Allowance	BCI pays 70% of Maximum Allowance after Deductible	BCI pays 70% of Maximum Allowance after Deductible
Other Dental Services (Occlusal Guards, Sealants, Amalgam Restorations and Resin-Composite Restorations)	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 70% of Maximum Allowance after Deductible	BCI pays 70% of Maximum Allowance after Deductible
Basic Dental Services	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 50% of Maximum Allowance after Deductible	BCI pays 50% of Maximum Allowance after Deductible
Major Dental Services (I*mplants are limited to a lifetime Benefit Limit of $900 per tooth, per Insured*) Twelve (12) month waiting period for Crowns, Bridges, Dentures and Dental Implants, including related services for all new Enrollees	BCI pays 50% of Maximum Allowance after Deductible	BCI pays 50% of Maximum Allowance after Deductible	BCI pays 50% of Maximum Allowance after Deductible
Orthodontic Services *(for eligible dependent children up to age 19 if the treatment has begun by age 17)* Twelve (12) month waiting period for Orthodontic Services for new Enrollees	BCI pays 50% of Maximum Allowance	BCI pays 50% of Maximum Allowance	BCI pays 50% of Maximum Allowance

MORE ABOUT YOUR DENTAL PLAN BENEFITS

Filing Claims

Soon after you complete initial enrollment, Blue Cross will send you a member identification card. When you use a contracting provider, your provider will use the information on your identification card to bill the carrier directly and you won't have to file a claim.

If you use a non-contracting provider, you may have to file a claim for reimbursement. Just send a detailed invoice from your provider along with your name and member identification number to:

Blue Cross of Idaho
Attn: Claims
P.O. Box 7408
Boise ID 83707

LIFE INSURANCE PLANS

For the financial protection of your family, the State offers a variety of life insurance plans:

- **Basic Life:** *Automatic* for all eligible employees. The plan includes an Accidental Death & Dismemberment (AD&D) provision for employees only;
- **Voluntary Term Life:** *Optional plan* available to all eligible employees; and
- **State Police Optional Life:** *Optional plan* for all eligible police officer members of the Idaho State Police.

For details about the plans, please refer to the Principal Life Insurance Company contract.

HOW BASIC LIFE WORKS

If you die while insured, the plan will pay your full coverage amount to your beneficiary (benefits are reduced by twenty-five percent when employees attain age seventy and an additional twenty-five percent at age 75). As follows, coverage depends on your employee classification. Enrollment is automatic; however, you will need to designate a beneficiary. See your Human Resources or payroll office for details.

Employee Class	Employee Basic Life Benefit	Dependent Life Benefit
Class A – Certified Officials in active status who are elected Members of Legislature	$20,000	Spouse - $2,000 Dependent children - $1,000 each
Class B – Certified Officials not in Class A and all Employees in active status other than Class C employees; and **Class C** – Police officer members of the Idaho State Police as defined in Section 59-1303(3) of the Idaho Code	100% of annual salary (does not include overtime pay or bonuses). Minimum benefit: $20,000	Spouse - $2,000 Dependent children - $1,000 each

To determine the benefit, annual salary (does not include overtime pay or bonuses) is rounded up to the next $1,000 unless already a multiple of $1,000. For example, if your annual salary is:

- $34,000 per year, coverage would be $34,000; or
- $37,500 per year, coverage would be $38,000.

Terminally ill employees may apply for an *accelerated benefit*. Under this benefit, they may receive up to seventy-five percent (75%) of their Basic Life benefit amount while still living. The maximum $250,000. The amount paid to beneficiaries will be reduced by the amount paid out as an accelerated benefit, plus any associated interest charges.

HOW ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) WORKS

The Accidental Death and Dismemberment (AD&D) benefit is available *only* to eligible Class B and C employees. AD&D pays a percentage of your annual salary for certain serious physical losses, including loss of life, due to a covered accident. Benefits are reduced for employees age seventy (70) or older.

AD&D benefits are in addition to any paid by Basic Life benefits or other State life insurance plans.

Covered Loss	AD&D Benefit
Loss of Life	100% of annual salary
Loss of Any of These: • Both hands or both feet; • Both eyes; • One hand and one foot; • One hand and one eye; or • One foot and one eye.	100% of annual salary
Loss of One Hand, One Foot, or One Eye	50% of annual salary

"Loss" of a hand or foot means complete, permanent severance at or above wrist or ankle joint. Loss of an eye means the entire and irrevocable loss of sight.

HOW VOLUNTARY TERM LIFE WORKS

This plan allows you to purchase coverage in the amount of one, two or three times your annual salary (rounded up to the next $1,000 unless already a multiple of $1,000) with a minimum benefit of $20,000 and a maximum benefit of $500,000. And when you purchase coverage for yourself, you may also cover an eligible spouse for up to $50,000 (in increments of $10,000, and not in excess of the amount you purchase for yourself) and your children for $10,000. Benefits are reduced by twenty-five percent when an insured attains age seventy and an additional twenty-five percent at age 75.

Terminally ill employees may apply for an *accelerated benefit*. Under this benefit, they may receive up to seventy-five percent (75%) of their benefit amount, up to $250,000, while still living. The amount paid to beneficiaries will be reduced by the amount paid out as an accelerated benefit, plus any associated interest charges.

If you elect Voluntary Term Life coverage, the plan will pay benefits in addition to any paid by the Basic Life plan. See your Human Resource or payroll office for enrollment information.

HOW STATE POLICE OPTIONAL LIFE WORKS

This plan is available *only* to eligible **Class C employees,** police officer members of the Idaho State Police as defined in Section 59-1303(3) of the Idaho Code. Plan benefits equal $50,000, payable in addition to any benefits paid by other State life insurance plans.

MORE ABOUT YOUR LIFE INSURANCE BENEFITS

Your Beneficiary

This is the person you name to receive plan benefits if you die:

- Your beneficiary can be anyone you want;
- You can have different beneficiaries for each plan in which you are enrolled;
- You can have more than one (1) beneficiary per plan;
- You can change your beneficiary at any time simply by completing new forms; and

- If you die without a beneficiary, the plan will pay the benefit to the first of these survivors: your spouse, your children, your parents, your brothers and sisters, your executor or administrators.

You are the beneficiary for family members covered by for Basic Life.

Delay of Coverage

If you are not in active status the day life insurance coverage is supposed to begin, coverage will begin the day you return to work. For dependents who are hospitalized or home confined coverage begins when the period of limited activity ceases.

Filing Claims

Claims for life insurance benefits should be submitted as soon as possible after the loss, but no later than twelve (12) months from the date of loss. Claim forms are available from the Office of Group Insurance or your human resources or payroll office.

DISABILITY PLANS

The State's disability insurance plans can help replace a portion of your income if you are ever unable to work due to disability.

Disability benefits are provided only to eligible Class B and C employees in active status. If you are eligible, your coverage begins when your Basic Life coverage becomes effective, no special enrollment is required. The cost of the coverage is provided by the State as a portion of your Basic Life policy. For details about the plan, please refer to the contract.

HOW THE PLAN WORKS

To qualify for Short Term Disability (STD) and Long Term Disability (LTD) benefits, you must meet the plans' definition of *Total Disability or Residual Disability* as defined in the contract. This means:

- For the first thirty (30) months of disability, you are unable to perform the essential functions of your regular occupation and unable to earn more than seventy percent (70%) of your monthly salary; and
- After thirty (30) months of disability, you are unable to perform the essential functions of any occupation for which you are or may reasonably become qualified based on your education, training or experience, and you are unable to earn more than sixty (60%) of your monthly salary.

Plan	Waiting Period
Short Term Disability, benefits equal 60% of monthly pre-disability salary.	The longer of: • 30 continuous days of Total Disability, or • 30 continuous days of Residual Disability, or • The expiration of all accrued sick leave earned at the date of Disability
Long Term Disability, benefits equal 60% of your pre-disability monthly salary. Maximum benefit: $4,000 per month.	The longer of: • 26 continuous weeks of Total Disability or Residual Disability, or • The exhaustion of all sick leave earned as of the date of Total disability or Residual Disability

Other Sources of Income

Benefits from the State's disability plans are reduced by *income from other sources* you or your dependents receive or are eligible to receive. Examples of *other sources of income* include:

- Workers' Compensation;
- Social Security;
- Unemployment benefits;
- Employment rehabilitation earnings; and
- Certain retirement benefits.

Filing Claims

To apply for disability plan benefits, you must file a claim. To obtain a Disability Claim packet, contact the Office of Group Insurance at ogi@adm.idaho.gov or (208) 332-1860.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) offer a convenient and easy way to save money for eligible medical and dependent care expenses. If you are interested, you can participate in either or both of these plans, whatever suits your needs:

- **Medical Reimbursement Account:** Reimburses out-of-pocket health care costs not covered by any other plan; and

- **Dependent Care Account:** Reimburses the cost of dependent care necessary for you and your spouse to work or attend school full-time.

Elections you make when you enroll will apply for the entire Plan year, starting July 1 and continuing through June 30 unless you experience a qualifying family status change. For details about the plan, please refer to the plan document. If your employment terminates mid-plan year you may be eligible to continue Medical Reimbursement Account participation on a post-tax contribution basis under the provisions of the COBRA law; contact the Office of Group Insurance at 208-332-1863 for additional information.

HOW THE PLANS WORK

When you enroll, you elect how much you want to contribute to each FSA for the coming plan year. Your contributions are deducted from your paychecks on a pre-tax basis and go directly into the FSA of your choice under your name. When you incur an eligible expense, first you pay the bill out of your own pocket then you submit a claim for reimbursement. All medical Reimbursement Account claims must be accompanied by the Explanation of Benefits your insurance carriers send you when they process claims.

Here is how much you can contribute to each account:

- **Medical Reimbursement Account:** Maximum of $2,500 per plan year; and

- **Dependent Care Account:** **M**aximum of $5,000 per plan year.

You have until October 31 to file a claim for any expenses incurred during the preceding Plan year or its 75 day grace period.

It is important to keep in mind that the IRS says you must forfeit any money left in your FSA account after the filing deadline. If you are like most people, though, you should be able to avoid forfeiting money by realistically and conservatively choosing how much you are likely to need in the coming year.